DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: Pharmacists
All Prescribers
Managed Care Plans
Regional Administrators
CSO Administrators

Memorandum No. 03-08 MAA
Issued: April 1, 2003

For further information, go to:
http://maa.dshs.wa.gov/pharmacy/

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration (MAA)

Subject: **Prescription Drug Program - Updates**

This memorandum describes the following changes in the Medical Assistance Administration's (MAA) Prescription Drug Program effective May 1, 2003 (unless otherwise specified):

- Additions to MAA's Preferred Drug List in Therapeutic Consultation Services (TCS);
- Modifications and additions to the Expedited Prior Authorization criteria;
- Changes in Limitations of Certain Drugs; and
- Drug coverage changes to Prior Authorization.

Additions to MAA's Preferred Drug List in TCS

Non-preferred drugs in these classes will trigger a TCS review

Drug Class	Preferred Drug
Non-sedating antihistamines	Over-the counter (OTC) Loratadine

Replacement page F.1/F.2. is attached for MAA's Prescription Drug Program Billing Instructions, dated February 2003 reflecting the above addition.

☞ **See next page for more.**

Modifications of Expedited Prior Authorization (EPA) Criteria

Drug	Code	Criteria
Bextra® *(Valdecoxib)*		Before any code is allowed, the patient must: a) Have an absence of a history of ulcer or gastrointestinal bleeding, b) Have tried and failed or is intolerant to at least two generic NSAIDs, c) Be 18 years of age or older, d) Have an absence of a sulfa allergy, and e) Have an absence of history of rash while on Bextra.
	078	▪ Diagnosis of osteoarthritis or rheumatoid arthritis and dose is limited to 10mg per day.
	079	▪ Diagnosis of primary dysmenorrhea and does is limited to 20mg or less per day.
Celebrex® *(Celecoxib)*		Before any code is allowed, the patient must: a) Have an absence of a history of ulcer or gastrointestinal bleeding, b) Have tried and failed or is intolerant to at least two generic NSAIDs, c) Be 18 years of age or older, and d) Have an absence of a sulfa allergy.
	139	▪ Diagnosis of osteoarthritis and dose is limited to 200mg or less per day.
	140	▪ Diagnosis of rheumatoid arthritis and dose is limited to 400mg or less per day.
	145	▪ Diagnosis of colorectal polyps and dose is limited to 400mg or less per day. (Exempt from trial with two generic NSAIDs.)
	147	▪ Diagnosis of acute pain, including primary dysmenorrhea, and dose is limited to 600mg the first day and a maximum of 400mg on subsequent days.

Drug	Code	Criteria
Vioxx® *(Rofecoxib)*		Before any code is allowed, the patient must: a) Have an absence of a history of ulcer or gastrointestinal bleeding, b) Have tried and failed or is intolerant to at least two generic NSAIDs, and c) Be 18 years of age or older.
	050	▪ Diagnosis of rheumatoid arthritis and dose is limited to 25mg or less per day.
	051	▪ Diagnosis of osteoarthritis and dose is limited to 12.5 to 25mg per day.
	052	▪ Diagnosis of acute pain, including primary dysmenorrhea, and dose is limited to 50mg or less per day for five days.

Additions to Expedited Prior Authorization Codes

Drug	Code	Criteria
Effective February 11, 2003		
Strattera® *(Atomoxetine Hcl)*	007	All of the following must apply: a) Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD); and b) Patient is 6 years of age or older.
Week of May 5, 2003		
Wellbutrin SR® *(Bupropion SR)*	014	Treatment of depression

Replacement pages H.7-H.18 are attached for MAA's Prescription Drug Program Billing Instructions – Expedited Prior Authorization section, dated February 2003 reflecting the above changes and additions.

Changes in Limitations of Certain Drugs

Drug	Limit
Ambien®	30 in a 90 day period
Sonata®	30 in a 90 day period

To review MAA's current List of Limitations on Certain Drugs, go to: http://maa.dshs.wa.gov/pharmacy or email: providerinquiry@dshs.wa.gov for a hardcopy.

Drug Coverage Changes to Prior Authorization

Drug
Cerumenex® (OTC generic carbamide peroxide is an alternative that does not require prior authorization)
Non-preferred non-sedating antihistamines (Prescription Allegra®, Clarinex®, Claritin®, Zyrtec® and their combinations with decongestants)

Therapeutic Consultation Service (TCS)

[Refer to WAC 388-530-1260]

Overview of TCS

MAA provides a complete drug profile review for each client when a drug claim for that client triggers a TCS consultation. The purpose of TCS is to facilitate the appropriate and cost-effective use of prescription drugs. MAA-designated clinical pharmacists review profiles in consultation with the prescriber or the prescriber's designee by telephone.

TCS occurs when a drug claim:

- Exceeds four brand name prescriptions per calendar month; or
- Is for a nonpreferred drug within MAA's selected therapeutic classes (see MAA's Preferred Drug List on page F.2). **This does not apply to the Voluntary Preferred Drug List.**

When a pharmacy provider submits a claim that exceeds the TCS limitations for a client, MAA generates a Point-of-Sale (POS) computer alert to notify the pharmacy provider that a TCS review is required. The computer alert provides a toll-free telephone number (866) 246-8504 to the pharmacy for the prescriber or prescriber's designee to call.

Drugs excluded from the four brand name prescription per calendar month review

Drugs excluded from the four brand name prescription per calendar month review:

- Antidepressants
- Antipsychotics
- Anticonvulsants
- Chemotherapy drugs
- Contraceptives
- HIV medications
- Immunosuppressants
- Hypoglycemia rescue agents
- Generic drugs

Preferred Drug List

MAA chooses a drug or drugs from a selected therapeutic class for placement on the preferred list when:

- There is evidence that one drug has superior safety, efficacy, and effectiveness compared to others in the same drug class; or
- The drugs in the class are essentially equal in terms of safety and efficacy; and
- The selected drug or drugs may be the least costly in the therapeutic class.

Preferred Drug List

Selected Therapeutic Drug Class	Preferred Drug(s)
Histamine H2 Receptor Antagonist (H2RA)	Ranitidine
Proton Pump Inhibitors (PPIs)	Protonix® or Prevacid®
Non-sedating antihistamines	Over-the-counter (OTC) Loratadine

Voluntary Preferred Drug List

The following drug classes are voluntary preferred drugs that will be suggested to prescribers during TCS consultation. Non-preferred drugs in these drug classes will not trigger a review unless the request is the fifth request for a brand name drug in a calendar month.

Selected Therapeutic Drug Class	Preferred Drug(s)
Statin-type cholesterol-lowering agents	LDL lowering ≤30% = generic lovastatin LDL lowering ≥31% through 40% = Zocor® (first choice) or Lipitor® (second choice) LDL lowering ≥41% = Lipitor®. Pravachol® may be used when drug-drug interactions with concurrent drug therapy are likely (gemfibrozil, protease inhibitors)
Angiotensin-Converting Enzyme Inhibitors (ACE-I)	Generic captopril, enalapril and lisinopril

Drug	Code	Criteria
Abilify® *(Aripiprazole)*	015	All of the following must apply: a) There must be an appropriate DSM IV diagnosis as determined by a qualified mental health professional; and b) Patient is **18** years of age or older; and c) Must be prescribed by a psychiatrist, neurologist, or psychiatric ARNP with prescriptive authority approved for this drug class, or in consultation with one of the above.
Accutane® *(Isotretinoin)*		Must not be used by patients who are pregnant or who may become pregnant while undergoing treatment. The following conditions must be **absent:** a) Paraben sensitivity; b) Concomitant etretinate therapy; and c) Hepatitis or liver disease.
	001	Diagnosis of severe (disfiguring), recalcitrant cystic acne, unresponsive to conventional therapy.
	002	Diagnosis of severe, recalcitrant acne rosacea in adults unresponsive to conventional therapy.
	003	Diagnosis of severe keratinization disorders when prescribed by, or in consultation with, a dermatologist.
	004	Prevention of skin cancers in patients with xeroderma pigmentosum.
	005	Diagnosis of mycosis fungoides (T-cell lymphoma) unresponsive to other therapies.

Drug	Code	Criteria
Actonel® *(Risendronate Sodium)*	142	Treatment of Paget's disease of the bone at doses of 30mg per day for two months. Retreatment may be necessary with same dose duration.
	143	Prevention of osteoporosis in post-menopausal women at doses of 5mg per day when hormone replacement is contraindicated.
	144	Treatment of osteoporosis in post-menopausal women at doses of 5mg per day.
	146	Prevention and treatment of glucocorticoid-induced osteoporosis in men and women at doses of 5mg per day.
	148	Prevention and treatment of osteoporosis in post-menopausal women at doses of 35mg per week.
Adderall® *(Amphetamine/ Dextroamphetamine)*	026	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) and all of the following: a) The prescriber is an authorized schedule II prescriber; and b) Patient is **3** years of age or older.
	027	Diagnosis of narcolepsy by a neurologist or sleep specialist, following documented positive sleep latency testing and the prescriber is an authorized schedule II prescriber.
	087	Depression associated with end stage illness and the prescriber is an authorized schedule II prescriber.

Drug	Code	Criteria
Adderall XR® *(Amphetamine/ Dextroamphetamine)*	094	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) and all of the following: a) The prescriber is an authorized schedule II prescriber; and b) Patient is **6** years of age or older; and c) Total daily dose is administered as a single dose.
Adeks® Multivitamins	102	For the treatment of malabsorption conditions, especially those conditions that inhibit the absorption of fat-soluble vitamins (such as cystic fibrosis, steatorrhea, hepatic dysfunction, and cases of HIV/AIDS with malabsorption concern) and all of the following: a) Patient is under medical supervision; and b) Patient is not taking oral anticoagulants; and c) Patient does not have a history of or is not at an increased risk for stroke/thrombosis.
Advil® Suspension *(Ibuprofen suspension)*	038	Diagnosis of chronic inflammatory disease or syndrome such as Juvenile Rheumatoid Arthritis (JRA).
	073	Diagnosis of chronic pain and all of the following: a) Patient is **12** years of age or older; and b) Cannot swallow tablets; and c) Is intolerant to aspirin drug therapy.
	074	Diagnosis of chronic pain or sustained fever and all of the following: a) Patient is between six months and **12** years of age; and b) The patient has tried and failed acetaminophen elixir.
Aggrenox® *(Aspirin/ Dipyridamole)*	037	To reduce the risk of stroke in patients who have had transient ischemia of the brain or completed ischemic stroke due to thrombosis, and all of the following: a) The patient has tried and failed aspirin or dipyridamole alone; and b) The patient has no sensitivity to aspirin.
Ambien® *(Zolpidem tartrate)*	006	Short-term treatment of insomnia. Drug therapy is limited to a one month supply, after which the patient must be re-evaluated by the prescriber before therapy can be continued.

Drug	Code	Criteria
Amiodarone	010	Prescribed or recommended by a cardiologist/internist.
Angiotensin Receptor Blockers (ARBs)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor. **Atacand®** (Candesartan cilexetil) **Atacand HCT®** (Candesartan cilexetil/HCTZ) **Avalide®** (Irbesartan/HCTZ) **Avapro®** (Irbesartan) **Benicar®** (Olmesartan medoxomil) **Cozaar®** (Losartan potassium) **Diovan®** (Valsartan) **Diovan HCT®** (Valsartan/HCTZ) **Hyzaar®** (Losartan potassium/HCTZ) **Micardis®** (Telmisartan) **Micardis HCT®** (Telmisartan/HCTZ) **Teveten®** (Eprosartan mesylate) **Teveten HCT®** (Eprosartan mesylate/HCTZ)
Anzemet® *(Dolasetron mesylate)*	127	Prevention of nausea or vomiting associated with moderately to highly emetogenic cancer chemotherapy.
Aredia® *(Pamidronate disodium)*	011	Diagnosis of hypercalcemia associated with malignant neoplasms with or without metastases.
	016	Treatment of Paget's disease of the bone.
Aricept® *(Donepezil)*	022	Treatment of dementia of the Alzheimer's type according to the criteria established by the National Institute of Neurological Disorders and Stroke/Alzheimer's Disease Related Disorders Association (NINDS/ADRDA).

Drug	Code	Criteria
Avonex® *(Interferon beta 1-A)*	119	Prescribed by, or in consultation with a neurologist, for the treatment of relapsing multiple sclerosis (MS).
Azelex® *(Azelaic acid)*	101	Diagnosis of acne vulgaris in patients **12** years of age or older.
Betapace® *(Sotalol)*	010	Prescribed or recommended by a cardiologist/internist.
Betaseron® *(Interferon beta 1-B)*	012	Prescribed by, or in consultation with a neurologist, and clinically confirmed and/or laboratory/ imaging-confirmed diagnosis of relapsing/remitting multiple sclerosis (MS) and patient must be ambulatory.
Bextra® *(Valdecoxib)*		Before any code is allowed, the patient must: a) Have an absence of a history of ulcer or gastrointestinal bleeding; b) Have tried and failed or is intolerant to at least two generic NSAIDs; c) Be 18 years of age or older; d) Have an absence of sulfa allergy; and e) Have an absence of history of rash while on Bextra.
	078	Diagnosis of osteoarthritis or rheumatoid arthritis and dose is limited to 10 mg per day.
	079	Diagnosis of primary dysmenorrhea and dose limited to 20mg or less per day.
Calcimar® *(Calcitonin-salmon)*	016	Treatment of Paget's disease of the bone.
	017	Treatment or prevention of postmenopausal osteoporosis.
	123	Treatment of hypercalcemia.

Drug	Code	Criteria
Calcium w/vitamin D	126	Confirmed diagnosis of osteoporosis, osteopenia or osteomalacia.
Celebrex® *(Celecoxib)*		Before any code is allowed, the patient must: a) Have an absence of a history of ulcer or gastrointestinal bleeding; b) Have tried and failed or is intolerant to at least two generic NSAIDs; c) Be 18 years of age or older; and d) Have an absence of sulfa allergy.
	139	Diagnosis of osteoarthritis and dose is limited to 200mg or less per day.
	140	Diagnosis of rheumatoid arthritis and dose is limited to 400mg or less per day.
	145	Diagnosis of colorectal polyps and dose is limited to 400mg or less per day. (Exempt from trial with two generic NSAIDs.)
	147	Diagnosis of acute pain, including primary dysmenorrhea, and dose is limited to 600mg the first day and a maximum of 400 mg on subsequent days.
Children's Advil® *(Ibuprofen)*		See criteria for Advil® Suspension.

Drug	Code	Criteria
Clonazepam	099	Prescribed by, or in consultation with, a health care professional with prescriptive authority for this class of drug for psychiatric disorders meeting DSM IV diagnostic criteria on Axis I or II disorder (exclusive of disorders related to substance abuse and childhood related disorders).
	100	Prescribed for neurologic disorders including Lennox Gastaut Syndrome, akinetic and myoclonic seizures, and absence seizures which have failed to respond to succinimides or when prescribed for restless leg syndrome.
	120	Prescribed in consultation with a pain specialist for neuropathic pain.
	121	Prescribed for withdrawal syndromes for up to 30 days when related to alcohol, benzodiazepine, or barbituate use.
Clozapine Clozaril®	018	All of the following must apply: a) There must be an appropriate DSM IV diagnosis present as determined by a qualified mental health professional; and b) Patient is **17** years of age or older; and c) Must be prescribed by a psychiatrist, neurologist, or psychiatric ARNP with prescriptive authority approved for this drug class, or in consultation with one of the above.
Compazine® Spansules *(Prochlorperazine maleate)*	095	Treatment of nausea and vomiting due to oncology treatment. Patient must have tried and failed Compazine® tablets or suppositories.

Drug	Code	Criteria
Concerta® *(Methylphenidate)*	149	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) and all of the following: a) The prescriber is an authorized schedule II prescriber, and b) Patient is **6** years of age or older.
Copaxone® Injection *(Glatiramer acetate)*	013	Prescribed by, or in consultation with a neurologist, and clinically-confirmed and/or laboratory/imaging – confirmed diagnosis of relapsing/remitting multiple sclerosis (MS).
Cordarone® *(Amiodarone)*	010	Prescribed or recommended by a cardiologist/internist.
Cyanocobalamin Injection *(Vit. B-12 Injection)*	075	For the treatment of vitamin B-12 deficiency (pernicious anemia).
Danocrine® *(Danazol)*		Before any code is allowed, there must be an absence of all of the following: a) Pregnancy b) Breast feeding c) Undiagnosed genital bleeding d) Porphyria e) Impaired hepatic, renal, or cardiac function
	023	Diagnosis of laparoscopic-proven endometriosis.
	024	Diagnosis of fibrocystic breast disease with pain/tenderness/ nodularity.
	025	Diagnosis of hereditary angioedema in males or females.
Dexedrine® *(D-Amphetamine sulfate)*		See criteria for Adderall®.
Dextrostat® *(D-Amphetamine sulfate)*		See criteria for Adderall®.

Drug	Code	Criteria
Differin® *(Adapalene)*	055	Treatment of acne vulgaris.
Enemeez® *(Docusate sodium)*		See criteria for Therevac®**.**
Evista® *(Raloxifene Hcl)*	017	Treatment or prevention of postmenopausal osteoporosis.
	034	Prevention of postmenopausal osteoporosis when hormone replacement therapy is contraindicated.
Exelon® *(Rivastigmine tartrate)*		See criteria for Aricept®.
Focalin® *(Dexmethylphenidate)*		See criteria for Concerta®.
Fosamax® *(Alendronate sodium)*	016	Treatment of Paget's disease of the bone.
	017	Treatment or prevention of postmenopausal osteoporosis.
	106	Treatment of osteoporosis in males.
	122	Treatment of steroid-induced osteoporosis.
Geodon® *(Ziprasidone)*	046	All of the following must apply: a) There must be an appropriate DSM IV diagnosis as determined by a qualified mental health professional; and b) Patient is **6** years of age or older; and c) Must be prescribed by a psychiatrist, neurologist, or psychiatric ARNP with prescriptive authority approved for this drug class, or in consultation with one of the above.

Drug	Code	Criteria
***Note:**		Because Geodon® prolongs the QT interval (> Seroquel® > Risperdal® > Zyprexa®) it is contraindicated in patients with a known history of QT prolongation (including congenital long QT syndrome), with recent acute myocardial infarction, or with uncompensated heart failure; and in combination with other drugs that prolong the QT interval.
Ibuprofen Suspension		See criteria for Advil® Suspension.
INFeD® (*Iron dextran)*		028 Diagnosis of iron deficiency and all of the following: a) Inability to tolerate any oral form of iron therapy; and b) The rate of continuing blood loss exceeds the rate at which iron can be absorbed from oral ferrous sulfate.
		029 Diagnosis of iron deficiency and all of the following: a) Inability to tolerate any oral form of iron therapy; and b) Immediate iron replacement is necessary to avoid blood product transfusions.
Infergen® *(Interferon alfacon-1)*	134	Treatment of chronic hepatitis C viral (HCV) infection in patients **18** years of age or older with compensated liver disease who have anti-HCV serum antibodies and/or presence of HCV RNA.
Intron A® *(Interferon alpha-2b recombinant)*	030	Diagnosis of hairy cell leukemia in patients **18** years of age or older.
	031	Diagnosis of recurring or refractory condyloma acuminata (external genital/perianal area) for intralesional treatment in patients **18** years of age or older.
	032	Diagnosis of AIDS-related Kaposi's sarcoma in patients **18** years of age or older.
	033	Diagnosis of chronic hepatitis B in patients **1** year of age or older.
	107	Diagnosis of malignant melanoma in patients **18** years of age or older.
	109	Treatment of chronic hepatits C in patients **18** years of age or older.
	135	Diagnosis of follicular non-Hodgkin's lymphoma in patients **18** years of age or older.
Klonopin® *(Clonazepam)*		See criteria for Clonazepam.
Kytril® *(Granisetron)*	127	Prevention of nausea or vomiting associated with moderately to highly emetogenic cancer chemotherapy.
	128	Prevention of nausea or vomiting associated with total body or abdominal radiotherapy.
Marinol® *(Dronabinol)*	035	Diagnosis of cachexia associated with AIDS.
	036	Diagnosis of cancer and failure of all other drugs to adequately treat nausea and vomiting related to radiation or chemotherapy.
Metadate CD®		See criteria for Concerta®.
Miacalcin® *(Calcitonin-salmon)* **Miacalcin Nasal Spray®** *(Calcitonin-salmon)*		See criteria for Calcimar®.

Drug	Code	Criteria
Miralax® *(Polyethylene glycol 3350)*	021	Treatment of occasional constipation. Must have tried and failed a less costly alternative.
Motrin® Suspension *(Ibuprofen suspension)*		See criteria for Advil® Suspension.
Naltrexone		See criteria for ReVia®.
Nembutal® Sodium *(Pentobarbital sodium)*		See criteria for Seconal Sodium®.
Nephrocaps®	096	Treatment of patients with renal disease.
Nephro-FER® *(Ferrous Fumarate/ Folic acid)*		
Nephro-Vite® *(Vitamin B Comp W-C)*		
Nephro-Vite RX® *(Folic acid/Vitamin B Comp W-C)*		
Nephro-Vite +FE® *(Fe fumarate/FA/ Vitamin B Comp W-C)*		
Nephron FA® *(Fe fumerate/Doss/ FA/B Comp & C)*		
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)	141	An absence of a history of ulcer or gastrointestinal bleeding.

Ansaid® (Flurbiprofen)
Arthrotec® (Diclofenac/misoprostol)
Clinoril® (Sulindac)
Daypro® (Oxaprozin)
Feldene® (Piroxicam)
Ibuprofen
Indomethacin
Lodine®, **Lodine XL®** (Etodolac)
Meclofenamate
Mobic® (Meloxicam)
Nalfon® (Fenoprofen)
Naprosyn® (Naproxen)
Orudis®, **Oruvail®** (Ketoprofen)
Ponstel® (Mefenamic acid)
Relafen® (Nabumetone)
Tolectin® (Tolmetin)
Toradol® (Ketorolac)
Voltaren® (Diclofenac)

Drug	Code	Criteria
Oxandrin® *(Oxandrolone)*		Before any code is allowed, there must be an absence of all of the following: a) Hypercalcemia b) Nephrosis c) Carcinoma of the breast d) Carcinoma of the prostate e) Pregnancy
	110	Treatment of unintentional weight loss in patients who have had extensive surgery, severe trauma, chronic infections (such as AIDS wasting), or who fail to maintain or gain weight for no conclusive pathophysiological cause.
	111	To compensate for the protein catabolism due to long-term corticosteroid use.
	112	Treatment of bone pain due to osteoporosis.
Pacerone® *(Amiodarone)*	010	Prescribed or recommended by a cardiologist/internist.
PEG-Intron® *(Peginterferon alpha 2b)*	109	Treatment of chronic hepatitis C in patients **18** years of age or older.
Pegasys® *(Peginterferon alpha-2a)*	109	Treatment of chronic hepatitis C in patients **18** years of age or older.
Plavix® *(Clopidogrel bisulfate)*	136	For use in patients with atherosclerosis documented by recent myocardial infarction, recent stroke, or established peripheral artery disease and have failed aspirin. A patient that is considered an aspirin failure has had an atherosclerotic event (MI, stroke, intermittent claudication) after the initiation of once a day aspirin therapy.

Drug	Code	Criteria
Pulmozyme® *(Deoxyribonuclease)*	053	Diagnosis of cystic fibrosis and the patient is **5** years of age or older.
Rebetron® *(Ribaviron/interferon alpha-2b, recombinant)*	008	Treatment of chronic hepatitis C in patients with compensated liver disease who have relapsed following alpha interferon therapy.
	009	Treatment of chronic hepatitis C in patients with compensated liver disease.
Rebif® *(Interferon beta-1A/albumin)*		See criteria for Betaseron®.
Reminyl® *(Galantamine hydrobromide)*		See criteria for Aricept®.
Rena-Vite® **Rena-Vite RX®** *(Folic Acid/Vit B Comp W-C)*	096	Treatment of patients with renal disease.
ReVia® *(Naltrexone)*	067	Diagnosis of past opioid dependency or current alcohol dependency. Must be used as adjunctive treatment within a state-certified chemical dependency treatment program. For maintenance of opioid-free state in a detoxified person, treatment may be started only after a minimum of 7-10 days free from opioid use. Treatment period must be limited to 12 weeks or less, and the patient must have an absence of all of the following: a) Acute liver disease; and b) Liver failure; and c) Pregnancy. **Note:** A certification form must be on file with the pharmacy before the drug is dispensed. *(Sample copy of form attached.)*

Drug	Code	Criteria
Rilutek® *(Riluzole)*	089	Confirmed diagnosis of Amyotrophic Lateral Sclerosis (ALS) (Lou Gehrig's Disease) and the prescription is written by, or in consultation with, a neurologist.
Risperdal® *(Risperidone)*	054	All of the following must apply: a) There must be an appropriate DSM IV diagnosis as determined by a qualified mental health professional; and b) Patient is **6** years of age or older; and c) Must be prescribed by a psychiatrist, neurologist, or psychiatric ARNP with prescriptive authority approved for this drug class, or in consultation with one of the above.
	104	Treatment of dementia-related disturbed behavior in patients **18** years of age or older.
Ritalin LA®		See criteria for Concerta®.
Roferon-A® *(Interferon alpha-2b recombinant)*	030	Diagnosis of hairy cell leukemia in patients **18** years of age or older.
	032	Diagnosis of AIDS-related Kaposi's sarcoma in patients **18** years of age or older.
	080	Diagnosis of chronic phase, Philadelphia chromosome (Ph) positive chronic myelogenous leukemia (CML) when treatment started within one year of diagnosis.
	109	Treatment of chronic hepatitis C in patients **18** years of age or older.

Drug	Code	Criteria
Rythmol® *(Propafenone)*	010	Prescribed or recommended by a cardiologist/internist.
Sandostatin® *(Octreotide acetate)*	056	Diagnosis of severe diarrhea and flushing due to metastatic carcinoid tumor.
	057	Diagnosis of therapeutically unresponsive severe diarrhea due to vasoactive intestinal polypeptide tumor (VIPoma).
	058	Diagnosis of AIDS with refractory diarrhea.
	098	Reduction of blood levels of growth hormone and IGF-I in acromegaly patients who have inadequate response or cannot be treated by surgical resection, pituitary irradiation, or bromocriptine mesylate at maximum tolerated doses.
Seconal Sodium® *(Secobarbital sodium)*	090	Limited to a one-week supply for pregnant women in the third trimester immediately preceding delivery.
Seroquel® *(Quetiapine fumarate)*	054	All of the following must apply: a) There must be an appropriate DSM IV diagnosis as determined by a qualified mental health professional; and b) Patient is **6** years of age or older; and c) Must be prescribed by a psychiatrist, neurologist, or psychiatric ARNP with prescriptive authority approved for this drug class, or in consultation with one of the above.
Sonata® *(Zaleplon)*		See criteria for Ambien®.
Soriatane® *(Acitretin)*	064	Treatment of severe, recalcitrant psoriasis in patients **16** years of age or older. Prescribed by, or in consultation with, a dermatologist, and the patient must have an **absence** of all of the following: a) Current pregnancy or pregnancy which may occur while undergoing treatment; and b) Hepatitis; and c) Concurrent retinoid therapy.
Strattera® *(Atomoxetine Hcl)*	007	All of the following must apply: a) Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD); and b) Patient is 6 years of age or older.
Synarel® *(Nafarelin acetate)*	059	Diagnosis of endometriosis amenable to hormonal management in patients **18** years of age or older. Treatment limited to six months. Patient must have an **absence** of all of the following: a) Pregnancy; and b) Breast-feeding; and c) Hypersensitivity to GnRH.
	060	Diagnosis of central precocious puberty (CPP).
Talacen® *(Pentazocine/ acetaminophen)* **Talwin NX®** (*Pentazocine)*	091	Patient must be **12** years of age or older and has tried and failed two NSAIDs or failed one other narcotic analgesic and is allergic or sensitive to codeine.
Tambocor® *(Flecainide acetate)*	010	Prescribed or recommended by a cardiologist/internist.

Drug	Code	Criteria
Therevac Plus® *(Docusate sodium benzocaine)* **Therevac SB**® *(Docusate sodium)*	065	Diagnosis of any of the following and the patient has tried and failed at least 3 other agents/modalities: a) Quadriplegia or paraplegia; b) Severe cerebral palsy; or c) Severe muscular dystrophy.
Ticlid® *(Ticlopidine)*	066	Diagnosis of stroke or stroke precursors, or for patients who have had a thrombotic stroke. The patient must be intolerant to aspirin.
Tonocard® *(Tocainide)*	010	Prescribed or recommended by a cardiologist/internist.
Vancomycin®	069	Diagnosis of clostridium difficile toxin and the patient has failed to respond after two days of metronidazole treatment or the patient is intolerant to metronidazole.
Vancomycin® IV/Inj.	103	Treatment of patients with methacillin resistant staph aureaus infections.
Venofer® *(Iron sucrose complex)*		See criteria for INFeD®.

Drug	Code	Criteria
Vioxx® ***(Rofecoxib)***		Before any code is allowed, the patient must: a) Have an absence of a history of ulcer or gastrointestinal bleeding; b) Have tried and failed or is intolerant to at least two generic NSAIDs; and c) Be 18 years of age or older.
	050	Diagnosis of rheumatoid arthritis and dose limited to 25mg or less per day.
	051	Diagnosis of osteoarthritis and dose limited to 12.5 to 25mg per day.
	052	Diagnosis of acute pain, including primary dysmenorrhea and dose is limited to 50mg or less per day for 5 days.
Vitamin ADC Drops	093	The child is breast-feeding, and: a) The city water contains sufficient fluoride to contraindicate the use of Trivits w/Fl; and b) The child is taking medications which require supplemental Vitamin D, as determined medically necessary by the prescriber and cannot be obtained by any other source.
Vitamin B-12 Injection	075	For the treatment of vitamin B-12 deficiency (pernicious anemia).

Drug	Code	Criteria
Vitamin E	105	Confirmed diagnosis of tardive dyskinesia or is clinically necessary for Parkinsonism and all of the following: a) Caution is addressed for concurrent anticoagulant treatment; and b) Dosage does not exceed 3,000 IU per day.
Wellbutrin SR® *(Bupropion SR)*	014	Treatment of depression.
Zenapax® *(Daclizumab)*	138	For prophylaxis of acute organ rejection in patients receiving renal transplants when used as part of an immunosuppressive regimen that includes cyclosporine and corticosteroids.
Zofran® *(Odansetron)*		See criteria for Kytril®
Zometa® *(Zoledronic acid)*	011	Diagnosis of hypercalcemia associated with malignant neoplasms with or without metastases.

Drug	Code	Criteria
Zovirax® Oint *(Acyclovir)*		Before any code is allowed, there must be an **absence** of pregnancy.
	070	Diagnosis of shingles or immunodeficiency, and the patient has a contraindication to, or intolerance for, oral Zovirax®.
	071	Diagnosis of herpes simplex, types 1 & 2; varicella-2 zoster; or immuno-deficiency, and the patient has a contraindication to, or intolerance for, oral Zovirax®.
	072	Diagnosis of non-life threatening mucocutaneous herpes simplex virus infection or immunodeficiency, and the patient has a contraindication to, or intolerance for, oral Zovirax®.
Zyprexa® **Zyprexa Zydis®** *(Olanzapine)*		See criteria for Risperdal®.

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